

## Medical Memoranda

### A Case of Clicking Ears

Though subjective sensations of noises in the ears are common enough, the emanation of sounds audible to others seems a phenomenon worthy of record.

#### CASE REPORT

The patient, a British soldier aged 22, was sent into an Indian psychiatric hospital because of nightmares in which he flung himself about and called out for a rifle. They had occurred for twelve months, and appeared to be related to experiences under shell-fire and V1 bomb attacks in 1944. They ceased following two pentothal sessions and other psychotherapy. He also drew attention to a clicking noise which was audible to himself and others, and which he first noticed three months ago, 24 hours after a football had hit him on the cheek. The noise was heard when the observer placed his ear a few inches from the patient's; it resembled the soft crackle of an electric spark. Each click was a short distinct noise which was repeated at slightly irregular intervals at an average rate of from 24 to 32 a minute. The clicks were synchronous in the two ears, and bore no time relation to the pulse, respiration, movement of the mandible, or swallowing; the drums were never seen to move, and the clicking was unaltered when the meatal pressure was raised or during Eustachian catheterization. Major Clark, otorhinolaryngologist, examined him, and reported that the hearing, the appearance of the drums, and the Rinne and Weber tests were normal. The nasal airway was clear, though there was slight deviation of the septum to the right. The Eustachian tubes were patent. Over a period of two months' observation the sound was never absent when listened for except under pentothal or during sleep, when it ceased; the patient said that he could always hear it if he directed attention to it, though he noticed it chiefly at night. Complete physical examination and radiography of the skull were normal.

The patient gave the history that when he was 6 he developed a facial tic; he blinked his eyes, and screwed up his nose to one side. The condition lasted two years. When he was serving in B.L.A. he noticed that he was blinking excessively.

#### COMMENT

Spasmodic contraction of the stapedius or tensor tympani muscles analogous to facial tic appears the most likely cause of the phenomenon.

ELLIOTT EMANUEL, B.M., B.Ch., D.C.H.

### A Case of Infectious Mononucleosis Requiring Tracheotomy

Shirley Smith and Shaw (1945) have reported dramatic improvements in several cases of anginous glandular fever after injection of neosarsphenamine. In the case reported below the rapid disappearance of fever, angina, and adenopathy after the injection strongly suggested a specific effect. The asphyxia attack—presumably due to oedema of the glottis—occurred twelve hours after the injection. It is felt that it may have been precipitated by a process analogous to the Herxheimer reaction.

#### CASE REPORT

A previously healthy soldier aged 20 was admitted to hospital on Nov. 17 complaining of sore throat and malaise of three days' duration. On examination he was febrile but did not look unduly ill. The throat was generally inflamed, and there was a patchy exudate on both tonsils. The most striking feature was a gross enlargement of all the cervical lymph glands, producing an appearance of "bull neck." A tentative diagnosis of glandular fever was made, but it was felt that antidiaphtheric treatment should not be withheld. Accordingly, 48,000 units of antidiaphtheria serum were given intravenously, and a course of intramuscular penicillin begun, with an initial dose of 50,000 units followed by 20,000 units three-hourly for three days. A throat swab taken on admission grew only non-haemolytic streptococci.

During Nov. 18 and 19 there was no response to specific treatment. Nasal obstruction developed with a mucopurulent discharge from the right nostril. The cervical lymph glands became even larger, and in addition tender glands appeared in the axillae and groins. The spleen was not palpable. Fever persisted, the temperature rising to 103° F. (39.4° C.), and the patient became restless and confused. The urine now contained a gross amount of albumin but no casts. Throat and nose swabs taken on the 19th grew only non-haemolytic streptococci. A white blood count done on the same day gave a total of 11,500 (polymorphs 58%; lymphocytes 20%; abnormal cells of mononuclear origin 22%, showing pseudopodial projections and indentation of the nucleus).

During Nov. 20 and 21 there was little change in the physical signs, but the patient's general condition deteriorated, and he became disorientated and incontinent of urine. A further blood count gave the following results: R.B.C., 5,100,000; Hb, 15.4 g. per 100 ml.;

W.B.C., 15,400 (polymorphs 37%; lymphocytes 16%; abnormal cells 47%, showing a foamy cytoplasm, coarse granules, pseudopodia, etc.). On the 21st there was little change in the patient's condition. Breathing was not unduly laboured, and it was decided to give him an intravenous injection of neosarsphenamine, 0.45 g., at 5.30 p.m.; the urine then contained only a faint trace of albumin and no casts. There was no immediate reaction.

At 5 a.m. on the 22nd the patient developed respiratory distress and rapidly became completely obstructed. Emergency tracheotomy was performed by Lieut.-Col. Jelly, R.A.M.C., at 5.45 a.m., by which time breathing had ceased and the pulse was scarcely perceptible. After artificial respiration had been performed the condition of the patient rapidly improved, and within six hours he was conscious, rational, and could breathe easily past the tube. The cervical glands subsided rapidly and were noticeably softer to the touch. On the morning of the 24th the tube was removed. Temperature and pulse had dropped to normal and remained so. The throat was clear of exudate and the adenitis was rapidly resolving. Thereafter recovery was remarkably rapid and complete. Serum taken sixteen days after the onset gave a positive Paul-Bunnell reaction to a titre of 1/256/trace/512.

Thanks are due to Col. J. J. Biggam, M.C., late R.A.M.C., Officer Commanding, 84 Military Hospital, B.A.O.R., for permission to publish the case, and to Lieut.-Col. A. C. Dornhorst, R.A.M.C., Officer Commanding, Medical Division, 84 Military Hospital, for his help and interest.

G. B. T. STORY, M.B., Ch.B.,

Major, R.A.M.C., Medical Specialist.

A. F. MACCABE, M.B., Ch.B., D.P.H.,

Major, R.A.M.C., Pathologist.

B.A.O.R.

#### REFERENCE

Smith, K. Shirley, and Shaw, T. B. (1945). *British Medical Journal*, 1, 581.

### Acute Appendicitis and Direct Inguinal Hernia

An acutely inflamed appendix lying in any hernial sac is a quite infrequent occurrence, but still more rare is its association with the uncommon type of direct inguinal hernia.

#### CASE REPORT

A healthy man aged 40 was admitted to the Royal Infirmary, Edinburgh, in June, 1943, with a history of five days' generalized intermittent abdominal pain and nausea. The day previously the pain had become worse and settled in the right iliac fossa, but the bowels were acting regularly. A firm, rounded, tender swelling about 1 in. (2.5 cm.) in diameter was palpable on the right side 1½ in. (3.8 cm.) superior to the inguinal ligament and near the internal inguinal ring. It could be grasped between the finger and thumb and, except for its site, resembled a small strangulated femoral hernia. It did not pass as far down as the external ring and was irreducible. There was slight tenderness in the right iliac fossa, the tongue was slightly furred, and temperature, pulse, and respirations were normal. The diagnosis was not certain: appendicitis, inguinal hernia with a Richter strangulation, and glandular enlargement were possibilities.

Operation was performed under spinal analgesia, and the usual skin incision for an inguinal hernia was made. When the swelling was adequately exposed it was found to be unconnected with the internal inguinal ring, lying medial to the deep epigastric artery, and was a short, congested, direct inguinal hernial sac. A small mass of omentum was found adhering to the fundus of the sac, and was wrapped around an acutely inflamed appendix. This was removed via the sac, which was then excised. The herniation had taken place through a localized opening with firm edges (about 3/4 in. (2 cm.) diameter) in the transversalis fascia. An uneventful recovery took place.

#### COMMENT

Ogilvie (1937) was probably the first to describe a rare variety of direct inguinal hernia, which consists of a tubular process of peritoneum emerging through a circular deficiency with firm, tendinous margins in the transversalis fascia medial to the deep epigastric artery. Gill (1939) reported three cases and noted a fourth, the bladder wall being present in some and a Richter's strangulation in one, while MacLeod (1939), Warren (1939), Dodd (1939), Wimberger (1939), Dorling (1939), and Ewing (1943) recorded about a dozen more. The occurrence of acute appendicitis in a hernial sac has been recorded more often, and forms about 1% of all herniae (Wakeley, 1938). This case illustrates the association of two uncommon conditions and no reference to a previous case has been found.

Edinburgh.

J. F. CURR, M.D., F.R.C.S.Ed.

#### REFERENCES

- Dodd, H. (1939). *British Medical Journal*, 1, 471.  
Dorling, G. C. (1939). *Ibid.*, 1, 642.  
Ewing, M. R. (1943). *Ibid.*, 1, 612.  
Gill, W. G. (1939). *Ibid.*, 1, 263.  
MacLeod, C. (1939). *Ibid.*, 1, 414.  
Ogilvie, W. H. (1937). In *Maingot's Post Graduate Surgery*, Medical Publications, Ltd., London.  
Wakeley, C. P. G. (1938). *Lancet*, 2, 1282.  
Warren, R. (1939). *British Medical Journal*, 1, 471.  
Wimberger, W. E. (1939). *Ibid.*, 1, 471.